Bidder Questions and Answers - 1:

Budget/Financial Questions:

1. Please provide more information and explain the assumptions about the magnitude of these grants and approximate number of clients you expect to be served by each pilot project.

Bidders should tell us in their proposals how many clients they can serve. This project will not award grants, but contracts paid on a per member/per month basis for case management. Medical costs will be paid to providers separately.

Additionally, how do potential budget assumptions reconcile with potential mandatory enrollment provisions? For example, in Region 5 there are over 5,800 adults that could qualify for this project under mandatory/default enrollment. If we apply the potential $30 pm/pm payment that translates into a potential budget of $480 per member for the 16 month grant period – or over $2.7 million. Can we plan for a budget of this magnitude?

Yes.

If not, what kinds of client focus can RFP respondents specify without being in conflict with your desire not to have diagnosis-specific proposals?

A bidder may submit a proposal that focuses on clients who have one particular disease, if the proposal clearly indicates the inclusion of coordination of care for co-morbid conditions. MAA will not entertain RFP responses that are limited to management of a single disease, because MAA FFS clients have multiple co-morbidities that must be considered in order to decrease overall costs and manage their care more effectively.

2. Please elaborate on the State's projected savings and source of funding (Section III Funding, page 5). Is the projected 5% savings $30.00 pm/pm or is the projected administrative cost of the program $30.00 pm/pm with the projected savings $75 pm/pm? If the projected 5% savings is $30 pm/pm then annual healthcare costs are $7200 ((30/.05*)12=7200) which is almost double the annual per member cost of $3,703 indicated Table A-2 of Exhibit G.

The $30 pm/pm is a case management fee. It is independent of the cost of providing medical care to the clients enrolled in this program. The medical costs will be paid fee for service by the Medical Assistance Administration (MAA). Project contractors will be expected to utilize the $30 pm/pm to provide whatever case management and/or coordination services that the clients need, and that includes any incentives that contractors think should be offered to providers.

The savings will come from the reduced fee for service payments. MAA expects 5% savings on the overall MAA medical expenditures for clients that are enrolled in each of the contracted disease management/care coordination projects. We are currently working to develop a model that would measure each project's savings based on the

baseline data of the previous 12-months of claims data for each enrolled client. We are aware that there are complicating issues such as: clients who do not have 12 months of prior claims data, clients who enroll in the disease management program but disenroll before savings can be realized, and clients whose condition worsens. Final details regarding adjustments for disease progression and other outliers will be negotiated with successful bidders after the contracts have been awarded.

3. How realistic is it to be able to implement and document cost savings of 5% in a 13-month period (assumes 3 month start up time), given: a) the State's past experience with PCCM (increased utilization for some services at the start of the project), b) what best practice research indicates about chronic disease management process (time to implement behavior change), and c) other more rigorously evaluated disease management programs (time to set up and evaluate programs). Please provide more information about what the $1,000,000 gross savings is based on. Additionally, what is the legal nature of the guarantee to save money that you are seeking from contractors?

In the Funding section of the RFP (Page 3), it is stated, "The Legislature assumed a reimbursement rate of $30 pm/pm in order to achieve one million dollars in gross savings, $600,000 in net savings." Please specify the detailed assumptions behind this statement. In particular, to what does the reference to one million dollars in gross savings pertain?

We recognize that the timeline for the initiation of expected savings is extremely limited. In addition to looking at cost changes, we will include measurement of process or intermediate variables that would be consistent with eventual savings. We do expect that the mix of chronic conditions, risks, and diseases among our fee-for-service clients include some that will respond to coordination in the short-term as well as long-term.

The legislation that this project is driven by gives us the $1,000,000 gross savings as well as the 5% figure. We do not know the assumptions the Legislature used to determine the $1,000,000 figure; we were given the mandate to initiate a program to reach this savings. The $600,000 net savings will be for the total project, not for each of the contracted projects.

4. The RFP states that the successful contractor will be expected to guarantee at least 5% savings in "overall medical costs" (Exhibit B, Cost Proposal, Item #6) or "total medical expenditures" (Page 5, Disease Management Project Objectives, Item E) for the population served. Further, the contractor will be expected to provide a cost proposal that includes a portion of the fees withheld pending evaluation of the costs saved in the first year of the contract.

Please clarify how bidders are to calculate a guarantee of 5% cost savings in overall medical costs -- is there a specific formula that should be used?

Please see the answer to Question Number 2.

5. What is the DSHS' definition of "overall medical costs" and/or "total medical expenditures?" Is it gross medical costs per fee schedule, net medical costs paid out by the State after COB, co-pay, etc., or some other variant? Given the TCS initiative, does the definition include or exclude pharmacy costs?

Both terms refer to net medical costs paid by MAA after Coordination of Benefits, co-pays, and etc. The purpose of the TCS Initiative is to flag and review clients who have more than four prescriptions for name-brand medications. Savings on prescription drugs should not be a focus of your proposal and cost savings estimate, but should not be excluded from your proposal.

6. Care Management included medication management. According to the High Cost Medicaid Client study by Lerch and Mayfield referenced in the RFP, drugs account for approximately 27% of the claims expense for high cost Medicaid FFS Clients (those without any Medicare coverage). The RFP state (page 4) the "DM Project is not intended to focus cost containment on prescription drugs." Does this mean that in calculating DM savings the cost of prescription drugs will be excluded? Has the state included drug savings in its estimates of the savings resulting from the DM project?

Do not exclude the cost of prescription drugs from your proposal, but don't make savings on prescription drugs a focus of your proposal and cost savings estimate.

7. The statewide model covers "GAU and SSI eligible adult clients with multiple diseases and conditions." The data supplied with the RFP makes it difficult to determine which GAU/SSI clients have multiple diseases and conditions.

Bidders who requested additional data should have received raw data from which to make this determination.

8. What is DSHS' best estimate of: 1) total current GAU/SSI eligible adult population statewide and 2) number/percent of total GAU/SSI adult population with multiple diseases and conditions.

Please see the data tables attached to the RFP.

9. Can the proposed pm/pm fee for the statewide DM contractor be based upon the total eligible GAU/SSI adult population or is it limited to those who enroll in the disease management project?

The pm/pm rate for all projects will be paid for those clients enrolled in the program.

10. Withhold: Will the State consider responses that do not include a guarantee of at least a 5% savings in overall medical costs of the enrolled population? Our company is willing to put a portion of our program administrative budget at risk, however, we are not inclined to assume the risk associated with guaranteed savings.

Should 5% costs savings not be achieved, what is DSHS' understanding of the contractor's financial liability for the differential? In particular, is there a cap on the

contractor's liability should that differential amount exceed the contractor's program fees?

At the bidders conference you mentioned that administrative fees will be advanced to the providers if 5% savings is not met. Please clarify the providers' risk you addressed.

MAA will not consider proposals that do not guarantee a 5% savings. The financial risk bidders will take if the 5% savings is not achieved is for the $30 pm/pm case management fee paid by MAA, not for the medical costs incurred. Medical claims will be paid directly to providers independent of the disease management contracts.

11. Which organization currently adjudicates claims for the FFS MAA programs in Washington State? Is it contemplated that this organization will provide data directly to the successful DM Bidder, or will all data be provided through an intermediary organization such as the OMPRO? If the latter, what is the anticipated time lag between payment of claims by the claims adjudicator and availability of the claims information to the DM Contractor?

MAA does not have an outside claims adjudicator. MAA adjudicates approximately 1.5 million claims per month. Payment data can have a lag of 6 months to a year, because providers have up to 365 days to submit claims.

Eligibility data will be provided to contractors and is current data.

12. Please confirm that the State expects each contractor to fund a portion of up to $60,000 for program evaluation. How will these costs be apportioned, e.g., based on member months, equal share to each contractor.

Each contractor will be expected to fund a portion of the project evaluation – the amount will be based on the member months of each contractor's project.

13. Does the State place infant formula and prescription liquid dietary supplements under the pharmacy claims to be managed by Therapeutic Consultation Services and therefore not a focus of the DM project?

Infant formula and prescription liquid dietary supplements are not included in the Therapeutic Consultation Services.

14. Is there a possibility that funding will NOT be available for the 2nd and 3rd years of the contract?

Yes, there is the possibility that funding will not be available after the initial contract period. We believe continuation of this project is contingent upon showing cost savings through better coordinated care.

15. Is the required $600,000 savings a per contract savings, or an overall savings?

The $600,000 savings is total program savings, not per contract savings.

16. Please clarify that the $400,000 administrative costs will be paid as up-front costs.

There will be no up-front payment of administrative costs. Administrative costs will be paid from the $30pm/pm case management fees.

The $400,000 figure includes all program costs, including MAA staff.

17. Does the overall reduction in cost include only recognized comorbidities (ESRD, CAD, CHF) or does it include all costs such as broken legs - non related conditions?

Our legislative directive refers to all medical costs. The data indicate that our chronically ill fee-for-service clients have a number of co-morbid conditions, outside of those stated above, that aggravate their primary disease and its sequelae. The contractor must be prepared to coordinate with existing and potential state and community resources to reduce the overall costs. A random outlier like a broken leg should be filtered out in a large sample.

Data Questions

18. Is laboratory data (clinical data values for assisting in establishing baselines and interventions) available if the state contracts with a central lab?

MAA does not contract with a central lab. Claims data for laboratory services is included in the total MMIS claims data.

19. After contracts are awarded, how will updated client contact information be provided and how accurate is that expected to be?

Contact information will also be provided in the monthly report.

20. Will the data file allow analysis of termination and re-enrollment for clients moving in and out of the system? Particularly as they become ineligible for the pilot as they qualify for Medicare or other third party insurance.

The data will be refreshed and distributed to contractors monthly. Eligibility data is current and will allow contractors to review termination and re-enrollment in the program.

21. Will the data file (or other data source) provide information on clients' utilization rates and associated expenditures for mental health services, DDD, and AASA, and home health services?

We do not have information on expenditures made by other DSHS divisions available at this time. The medical claims information will be available.

22. Are the above services and expenditures captured as part of the total expenses per patient?

Each administration tracks the costs of services unique to their programs.

23. What happens regarding eligibility when clients transition between FFS and managed care? And will the data allow analysis of this?

Clients eligible for this program are not eligible for managed care. They will remain FFS.

24. Will the partner be able to work with MAA's PBM to coordinate information and develop seamless intervention strategies?

MAA does not have a Pharmacy Benefits Manager. The contractor will be able to work with MAA's Therapeutic Consultation Service to coordinate information and intervention strategies.

25. We are not sure what is meant by "the MAA will not entertain single disease approaches for statewide or local adult projects" (RFP – page 1).

A bidder may submit a proposal that focuses on clients who have one particular disease, if the proposal clearly indicates the inclusion of coordination of care for co-morbid conditions. MAA will not entertain RFP responses that are limited to management of a single disease, because MAA FFS clients have multiple co-morbidities that must be considered in order to decrease overall costs and manage their care more effectively.

26. Is default assignment (page 5) equal to an opt-out enrollment program?

Yes. Clients would be assigned to the Disease Management Program, and would have the ability to "opt-out" or disenroll from the program at any time.

27. Who is the outside evaluator for this pilot if known, or if not yet selected, how will the evaluator be selected? What are the criteria and process for selection of the external evaluation organization for the DM Project?

DSHS is coordinating with the Washington State Institute of Public Policy (WSIPP) and the University of Washington on the evaluation component of this project.

28. If we are a successful bidder, will the State provide monthly enrollment/eligibility data and monthly claims data so we can track program clients and identify potential new clients?

Yes, that data will be provided.

29. Will DSHS provide the successful bidder with an MAA Provider Database?

MAA has a database of all providers who have core provider agreements.

30. Is the expectation that the bidder is to manage an at-risk population vs. just a high-risk population (Exhibit B, Q3)?

The expectation is that the contractor will identify and manage both populations.

31. Will the MAA allow financial or other incentives for enrollment and retention of clients as part of their pm/pm's?

Monetary incentives are discouraged, since they can affect the client's income level for the purposes of assistance. Any other incentive would need MAA's approval prior to offering it.

32. What is CDPS and associated coefficients?

CDPS is the name of the risk stratification software used to prepare the data tables. It was developed by Rick Kronick at the University of California at San Diego.

33. Are all the data provided in Tables A through C for FFS clients? If not, will the data provided by OMPRO clearly identify the eligibility category to determine FFS clients?

All data in Tables A through C refer to FFS clients.

34. You clarified at the Bidders Conference that children can only be enrolled in the program on a voluntary basis. Once enrolled can they continue to seek service on their own from any provider in the fee for service program (in essence, can they be non-compliant). Can the DM contractor disenroll clients who we learn are chronically non-complaint with the DM Project and their specific care management plan?

Clients must be given a choice of providers and can be encouraged to stick with one provider. The Contractor may not disenroll clients based on their medical condition or non-compliance. MAA is interested in proposals that specifically address these hard to serve clients.

35. Page 2 of the RFP references MAA FFS programs such as the Categorically Needy, Medically Needy, General Assistance – Unemployable and Medically Indigent. However, the data Exhibit G, indicates that excluded from the population are the Medically Indigent, GAU – Institutionalized. Please clarify the target population for the local project serving high cost children. Which MAA fee for service program clients form the pool of children eligible for participation in the DM project and which MAA fee for service program clients are specifically excluded from participation in the DM project?

MAA clients who are institutionalized are excluded from participation in the DM project; the target population for the local project includes all other FFS clients.

36. Is the data available from the State sufficiently categorized to allow us to clearly identify clients in MAA FFS programs who are eligible for participation in the DM Project.

Yes, the data you have received shows information only for those clients likely to participate in the DM program.

37. Please clarify cost and demographics of the population excluded (members whose CDPS coefficient is above the 99.4th percentile) from the data tables (exhibit G). Do I understand correctly that these are the highest cost members? Why were they excluded? Are these members not eligible for participation in the DM Project?

They were excluded and analyzed separately because they are extremely high cost, and may be in their last months of life. However, MAA recognizes that coordination of care for these clients may result in both cost conservation and quality enhancement.

38. Please clarify where the monthly data feeds will come from.

The monthly data feeds will come from the Medical Management Information System (MMIS) which identifies eligibility data as well as medical claims.

Coordination/No Wrong Door

The Disease Management Project is the No Wrong Door project for MAA. Each Administration is expected to have a No Wrong Door project.

39. Please clarify your expectations of the relationship between the local DM service provider and the "No Wrong Door" program. Is it correct to assume the local DM contractor in essence becomes the hub that assures the coordination of various state program providers?

The DM Project contractor will not necessarily become the "hub" for coordination of state program services.

The DM Project contractor will be expected to work with No Wrong Door projects in areas where those projects exist, as they relate to coordination of services. In these cases, the DM Project contractor would attend No Wrong Door meetings as another case management provider. In areas where there is not a No Wrong Door project under another DSHS program, this DM Project will be a No Wrong Door project for MAA. The DM provider will be expected to coordinate with any existing DSHS case managers to support efforts to provide necessary medical services.

MAA assumes that the two projects will complement and assist one another in providing the best possible service to the clients enrolled in the project.

40. There seems to be the potential of two statewide initiatives that will also be responsible for implementing care coordination for clients: a) "No Wrong Door" and, b) "one contract for a statewide model, serving GAU and SSI eligible adults with multiple diseases and conditions." This raises two sets of questions.

First, who do you envision having primary care coordination responsibility and authority with the clients? How will the statewide initiatives work wit local care coordination efforts currently being implemented and the potential new pilots for adults? For

example, we are currently beginning the implementation of care coordination pilots with practitioners based on a model that has been developed locally/regionally with provider input. If we do not end up applying for and/or receiving a contract for this pilot project, how will the state initiatives work with us on our local/regional care coordination efforts with the target population and providers?

We envision that the client's medical home (their primary medical provider) and the DM case manager will provide primary care coordination and work with all/any case managers across the whole continuum of care. In many cases teaming with case managers from other DSHS programs that focus on social issues can result in stabilizing functional and heatlh status.

Second, what measures will be taken to ensure that DSHS internally manages the potentially divergent wishes of its own care coordination programs, so that coordination with them all is feasible within a tight contractor budget and timeline? For example, what level of review will be required for educational materials and/or approaches to care coordination being implemented by the pilots and how will the multiple DSHS player work together in the process? Who will be the primary contact for the contractor on this project?

We have already contacted our co-state agencies, which are aware of the DM project and support it. They will be contacting existing case managers to solicit and ensure their cooperation in this project. Representatives from the other state agencies will be meeting with us regularly to remain apprized of this initiative.

Educational materials for clients must be at 6th grade language and approved by DSHS.

41. In order to gain participation of primary care providers, will/can the State pay PCPs who care for children enrolled in the DM Project at a rate other than established DSHS rates? For example, we may want PCPs to be paid at 110% of DSHS rates each time they care for a DM Project client. Will the State do this?

No, any financial incentive for providers must come from the contractor.

42. Will the "No Wrong Door" client Registry be available to the Disease Management Contractors?

We are not certain at this time when this information will be available.

43. How will the DM contractor identify which existing State programs potential clients are already established with? Does the State have this information available via an electronic file the contractor will have access to?

The client file will have basic information on whether MAA clients have had contact with other DSHS programs.

44. Will the MAA assist in introducing the partner to various other case managers and healthcare providers as the "medical home" and encourage or mandate their participation? Particularly UM providers at time of hospitalization?

Yes.

45. Will the MAA assist in introducing the partner to community providers it does not make payments to but who the bidder may coordinate services with? Or allow the bidder to utilize MAA approved sanctioning of the bidder in its own communications?

Yes, MAA will introduce the contractors at regularly scheduled community meetings, and provide assistance in meeting community vendors and providers who do not regularly attend meetings.

46. You indicate that MAA will not entertain "single disease approaches for statewide or local adult projects." At the same time, you expect pilot projects to work with practitioners to implement evidence-based disease management protocols and standards for specific diseases. How do you reconcile these to apparently conflicting goals?

MAA expects bidders to recognize that many disease states also include multiple co-morbidities, and that these co-morbidities must be addressed in any care coordination plan.

47. What criteria will be required or allowed for excluding members once they are enrolled in the disease management program? For instance, if the member becomes institutionalized, or changes payor eligibility, is severely cognitively impaired, moves, chooses not to participate at any level, has a co-morbid condition (active malignancy) that precludes implementing evidence based guidelines for a condition, etc…..

Co-morbid conditions and cognitive impairment are NOT grounds for exclusion – these problems help define the target population of this RFP. Institutionalization, moving and changing eligibility to Medicare will be reason for exclusion.

48. If we choose to partner with an organization, must it be one of the respondents to the RFI, or can it be an organization that did not originally respond to the RFI?

The bidder must be an organization that responded to the RFI; you may partner with outside organizations, but you would be the bidder.

49. Do you have specific operational definitions for intermediate or longer-term outcomes? For example: increased access to preventive care, increased client education, and provider satisfaction with disease management.

No we do not have specific definitions. Bidders may propose outcome definitions in their response to the RFP.

50. The expectation that collateral materials be made available in English, Spanish and five additional languages is likely to be a significant cost burden – is there implementation funding available that will defray these and other innovative implementation costs that would also not count against the savings guarantee?

The expectation might better be stated: The Contractor will produce materials in a format(s) that meets the needs of the clients being served, whether that format is large print, audio tape, personal contact, etc. Client materials must be presented in a way that clients can understand.

Also, the languages that the contractors would be required to use for translation may vary from region to region – MAA will assist the contractor in determining which translations are appropriate for their service areas.

MAA may help defray some of the costs involved in translation of client materials but we these costs would count against the savings for the program.

51. Is there a requirement for a reading level for collateral material to clients? We notice the MAA informed consent form is probably at a high education level than might be expected for this population.

Client materials are expected to be written at sixth grade level. We are aware that the informed consent form is at higher than sixth grade reading level; DSHS staff are working to re-write the form so that it is more easily accessible to DSHS clients. We are also aware that there are many terms that are used for medical materials that affect the reading level of the materials.

52. Please clarify what materials you expect to receive with the bidders' RFP response regarding "samples of written materials that we will send to clients to inform them of the DM project and to promote their self-management"; do you want the bidders to provide you with marketing materials, disease management materials?

We would like to see materials that bidders have produced, either for prior disease management projects, or related kinds of projects – because our clients may have limited literacy (either as LEP clients, or low literacy English speaking clients), it is important that materials be clear and easy to read. You may use marketing materials as samples; however, marketing to these clients is prohibited.

Other issues

53. Whom does the evaluation panel consist of?

The evaluation panel will consist of state staff from DSHS, clinical and analytic experts from the Department of Health, and other stakeholder organizations.

54. Will information be made available to non-successful bidders regarding the deficiencies in their proposals and their relative rank in scoring?

Yes.

55. When would the first clients be enrolled into a program?

MAA anticipates having signed contracts in place for January 1, 2002. This would allow for at least two months of implementation prior to enrolling clients. The goal for enrolling clients is March 1, 2002.

56. Is the timeline for negotiating the final contract limited to two weeks?

MAA has allowed approximately two weeks for contract negotiation, in order to meet the goal of a January 1, 2002 contract start date. It is possible that negotiating the three contracts will take either more or less than two weeks.

57. What is the status of the amendment regarding voluntary enrollment?

MAA will submit a State Plan Amendment to the Centers for Medicare and Medicaid Services before the end of 2001. This amendment will call for mandatory enrollment with an "opt-out" provision.

58. How will local projects be carved out from State projects? The concern is that if the local projects awarded are in urban areas, and these populations are completely carved out, that is likely to adversely affect the state project. Recruitment potential would be lower, there may be differences in risk for a more heavily weighted rural population, and there may be less ability to deliver savings. Is there a way to prevent such a likely event?

Local projects will generally be on a smaller scale, with a more narrow focus than the state-wide projects.

59. Does MAA contract with a central laboratory for all lab work for FFS providers to use?

No.

60. Please confirm that the data file and the aggregate reports provided are for FFS clients who remained eligible for a 12 month period and who were never institutionalized during this period.

The data file reflects individuals who were eligible for Medicaid for a 12-month period and are currently eligible.

61. Is there any information or estimate on how many FFS clients would not be continuously eligible for 12 months or how many would become institutionalized during the 12-month period?

We do not have this information.

62. The average PPPY cost for a patient identified as having CHF (ICD-9 428) is quite high - almost $24,000. Please confirm that this population (and PPPY) is comprised of anyone who has the diagnosis, and not a separate high-risk subset. Also, if this is a population PPPY, does the MAA have any information as to why it would be so high?

No attempt was made to carve off any higher-than-average subset of the population identified as having CHF. The grouping logic was as described in the RFP documentation. We assume that the high average cost for this population is due to the large number of co-morbidities present, keeping in mind that the costs represent total annual costs, not just those costs directly associated with the listed diagnosis. In our analyses of other diagnosis categories we consistently found frequent occurrences of multiple diagnosis categories per patient, particularly mental health.

The population is limited to FFS clients, which are higher risk by definition. Their eligibility as adults implies long term disability. Most are SSI eligible. Costs include co-morbid conditions as well. Information as to where the costs lie is in the raw data file provided.

63. What other state initiatives/programs are under way or planned for 2002 that have an impact on the effect of a disease management program (e.g., diabetes self management training programs, provider training on evidence based guidelines, etc..)

Other initiatives include the pharmacy-based Therapeutic Consultation Service, the MAA Diabetes education benefit, and our involvement in the Diabetes and Asthma collaboratives with various clinical sites. Our asthma collaborative has included the development of a software package to facilitate patient management. MAA is also a member of the King County Asthma Forum and has been involved in the initiative to improve asthma care within King County. The Washington State Diabetes Collaborative has also been influential in the development and implementation of practice-based diabetes registry software that has been implemented in a number of clinical sites statewide that provide care to Medicaid clients.

64. Does MAA have a benefit and associated payment for diabetes self-management training? If so, what is the benefit and corresponding payment?

MAA has an education benefit for Diabetics. MAA does not pay for specific diabetes self-management training. Information about the diabetes benefit is included with the bidder questions and answers.

65. Can a bidder request a separate data file specific to its needs, even though it would not be able to be developed and used prior to the RFP? How would this process work if allowed?

After contracts have been awarded, MAA will work with the successful bidders to produce data that contractors need within the limitation of our resources and systems.

66. Are bidders permitted to enroll clients who qualify for both Medicaid and Medicare (or some other third party insurance coverage) -- or can enrollees only be covered by Medicaid and SSI?

At this time, MAA anticipates enrolling only those clients who are covered by Medicaid and SSI. Dual eligible Medicare/Medicaid clients will not participate in the project, nor will clients with comparable third party insurance.

67. Please clarify the external evaluation costs -- are you able to supply us with a formula to calculate expected costs to be borne by contractors? Can you give us an estimate in advance based on a smaller proportionate share of DM clients? When will contractors be expected to pay the cost of the external evaluation?

We will not know the proportion of the evaluation cost to be borne by each contractor until the bids are submitted.